BILLING CODE 4510-26-P

DEPARTMENT OF LABOR

Occupational Safety and Health Administration

29 CFR Part 1910

[Docket No. OSHA-2020-0004]

RIN: 1218-AD36

Occupational Exposure to COVID-19 in Healthcare Settings

AGENCY: Occupational Safety and Health Administration (OSHA), Labor.

ACTION: Notice of limited reopening of comment period; notice of informal hearing.

SUMMARY: OSHA is partially reopening the comment period to allow for additional public comment on specific topics and is scheduling an informal public hearing on its interim final rule establishing an Emergency Temporary Standard (ETS), "Occupational Exposure to COVID-19." The public hearing will begin on April 27, 2022.

DATES: *Comments:* Written comments in response to OSHA's limited reopening of the comment period must be submitted in Docket No. OSHA-2020-0004 on or before **[INSERT DATE 30 DAYS AFTER DATE OF PUBLICATION IN THE FEDERAL REGISTER]**.

Informal public hearing: The hearing will begin on April 27, 2022, and will be held virtually. If necessary, the hearing will continue on subsequent days. Additional information on how to access the informal hearing will be posted when available at *https://www.osha.gov/coronavirus/healthcare/rulemaking*. To testify at the hearing, interested persons must electronically submit their Notice of Intention to Appear

(NOITA) by **[INSERT DATE 14 DAYS AFTER PUBLICATION IN THE FEDERAL REGISTER]**.

ADDRESSES:

Notices of Intention to Appear: Notices of intention to appear at the hearing (NOITA) must be submitted electronically at *https://www.osha.gov/coronavirus/healthcare/rulemaking*. Follow the instructions online for making electronic submissions. See "Notices of Intention to Appear" in the **"SUPPLEMENTARY INFORMATION"** section of this document for additional requirements for NOITAs.

Written comments: You may submit comments and attachments, identified by Docket No. OSHA-2020-0004, electronically at *www.regulations.gov*, which is the Federal e-Rulemaking Portal. Follow the instructions online for making electronic submissions. After accessing "all documents and comments" in the docket (Docket No. OSHA-2020-0004), check the "proposed rule" box in the column headed "Document Type," find the document posted on the date of publication of this hearing notice, and click the "Comment Now" link. When uploading multiple attachments to *www.regulations.gov*, please number all of your attachments because *www.regulations.gov* will not automatically number the attachments. This will be very useful in identifying all attachments in the preamble. For example, Attachment 1 – title of your document, Attachment 2 – title of your document, Attachment 3 – title of your document. For assistance with commenting and uploading documents, please see the Frequently Asked Questions on *www.regulations.gov*.

Instructions: All submissions must include the agency's name and the docket number for this rulemaking (Docket No. OSHA-2020-0004). All comments, including any personal information you provide, are placed in the public docket without change and may be made available online at *www.regulations.gov*. Therefore, OSHA cautions commenters about submitting information they do not want made available to the public, or submitting materials that contain personal information (either about themselves or others), such as Social Security Numbers and birthdates.

Docket: To read or download comments and other materials submitted in the docket, or to view the hearing schedule and procedures when available, go to Docket No. OSHA-2020-0004 at *www.regulations.gov*. All comments and submissions are listed in the *www.regulations.gov* index; however, some information (e.g., copyrighted material) may not be publicly available to read or download through that website. All documents submitted to *www.regulations.gov*, including copyrighted material, are available for inspection through the OSHA Docket Office. Documents submitted to the docket by OSHA or stakeholders are assigned document identification numbers (Document ID) for easy identification and retrieval. The full Document ID is the docket number plus a unique four-digit code. OSHA is identifying supporting information in this rulemaking by author name and publication year, when appropriate. This information can be used to search for a supporting document in the docket at *www.regulations.gov*. Contact the OSHA Docket Office at (202) 693-2350 (TTY number: (877) 889-5627) for assistance in locating docket submissions. Please note that NOITAs will be gathered outside the docket and OSHA will add a list of individuals who have submitted NOITAs to the docket after the submission deadline has passed.

FOR FURTHER INFORMATION CONTACT:

For press inquiries: Contact Frank Meilinger, Director, Office of Communications, Occupational Safety and Health Administration, U.S. Department of Labor; telephone: (202) 693-1999; email: *OSHAComms@dol.gov*.

For general information and technical inquiries: Contact Andrew Levinson, Acting Director, Directorate of Standards and Guidance, Occupational Safety and Health Administration, U.S. Department of Labor; telephone: (202) 693-1950; email: *ETS@dol.gov*.

For Hearing Inquiries: Contact Amy Tryon, Division of Occupational Safety and Health, Office of the Solicitor, U.S. Department of Labor; telephone: (202) 693-8081; email: *ETS@dol.gov.*

SUPPLEMENTARY INFORMATION: On June 21, 2021, OSHA published an ETS to protect healthcare and healthcare support service workers from occupational exposure to COVID-19 in settings where people with COVID-19 are reasonably expected to be present (86 FR 32376). Although the ETS took effect immediately, OSHA also requested comment on whether it should become permanent, as well as on all other aspects of the ETS. OSHA received 481 comments concerning the ETS during the comment period, which was to end on July 21, 2021, but was extended to August 20, 2021, in response to requests from the public (86 FR 38232). To read or download comments and other materials submitted in the docket, go to Docket No. OSHA-2020-0004 at *www.regulations.gov*. In accordance with 29 U.S.C. 655(c)(3), the agency is now preparing to promulgate a final standard.

I. Additional Information and Request for Comment

OSHA is seeking public comment on certain specific topics and questions for the development of a final standard. Accordingly, the agency is partially reopening the comment period for the ETS to allow for additional comment on the topics identified below. OSHA encourages commenters to explain why they prefer or disfavor particular policy choices, and include any relevant studies, experiences, anecdotes, or other information that may help support the comment. OSHA seeks comments on the following topics:

A. Potential Changes From the ETS

The following is a list of potential rulemaking outcomes that would depart from the provisions of the ETS such that OSHA has decided to provide this additional notice and an opportunity to comment. OSHA has not made any decisions about these potential provisions or approaches, nor is this intended to list all of the potential changes from the ETS. Other changes may result after due consideration of all comments and hearing testimony.

A.1 - Alignment with CDC Recommendations for Healthcare Infection Control Practices: Evolving CDC recommendations have resulted in inconsistencies between those recommendations and some of the Healthcare ETS provisions (e.g., isolation and return-to-work guidance). A number of commenters requested that OSHA align its ETS more closely with various CDC recommendations. OSHA is considering doing so, but notes that, in some cases, CDC recommendations have continued to evolve even after the close of the comment period. OSHA is considering whether it is appropriate to align its final rule with some or all of the CDC recommendations that have changed between the close of the original comment period for this rule and the close of this comment period. OSHA seeks comment on this approach.

A.2 - Additional Flexibility for Employers: Some employers expressed concern that the provisions of the Healthcare ETS were overly prescriptive. The ETS, while rooted in a programmatic approach (e.g., COVID-19 plan, hazard assessment, policies and procedures to minimize the risk of transmission of COVID-19), also specified how employers were required to implement particular policies and procedures (e.g., criteria for medical removal and return to work, cleaning, ventilation, barriers, aerosol-generating procedures). OSHA is considering restating various provisions as broader requirements without the level of detail included in the Healthcare ETS and providing a "safe harbor" enforcement policy for employers who are in compliance with CDC guidance applicable during the period at issue. OSHA seeks comment on this approach.

A.3 - Removal of Scope Exemptions (e.g., ambulatory care facilities where COVID-19 patients are screened out; home healthcare): A final standard will be adopted under Section 6(b) of the OSH Act, which requires a finding of significant risk from exposure to COVID–19, rather than the finding of grave danger OSHA made in issuing the Healthcare ETS under Section 6(c) of the OSH Act. Section 6(b) requires that the standard substantially reduce or eliminate significant risk of material impairment of health to the extent feasible. In view of this different risk finding, OSHA is considering whether the scope of the final standard should cover employers regardless of screening procedures for non-employees and/or vaccination status of employees to ensure that all workers are protected to the extent there is a significant risk. OSHA seeks comment on this approach.

A.4 - Tailoring Controls to Address Interactions with People with Suspected or Confirmed COVID-19: OSHA is considering the need for COVID-19-specific infection

control measures in areas where healthcare employees are not reasonably expected to encounter people with suspected or confirmed COVID-19. This could include eliminating certain requirements that were included in the Healthcare ETS and that applied to all areas of covered healthcare settings. For example, OSHA could consider imposing cleaning requirements or medical removal provisions only with respect to staff exposed to COVID-19 patients or eliminating facemask requirements for staff not exposed to COVID-19 patients. If OSHA did restrict infection control requirements to particular areas of a facility or particular staff, it could consider balancing that narrower scope with a new "outbreak provision" to ensure that healthcare employers would still have a duty to address an outbreak quickly if an outbreak occurs among staff in the areas normally subject to fewer requirements. For example, an outbreak could trigger a broad performance requirement for the employer to implement additional infection control measures to stop the outbreak, or it could trigger more specific requirements, such as employer-provided testing and/or medical removal of staff with COVID-19 even if they do not interact with COVID-19 patients. OSHA seeks comment on these approaches, including comment on how OSHA should define an "outbreak" if it were to implement that approach (the CDC discusses "outbreaks" at *https://www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing/contact-tracing-plan/outbreaks.html*).

A.5 – Vaccination

A.5.1 - Booster Doses: In the ETS, certain requirements take account of whether individuals are "fully vaccinated," which is defined in paragraph (b) of the ETS as meaning "2 weeks or more following the final dose of a COVID-19 vaccine." Subsequent to the publication of the ETS, the Advisory Committee on

Immunization Practices (ACIP) has recommended additional doses and booster doses. CDC has also adopted the concept of "up to date" to describe vaccination recommendations beyond the primary vaccination series. OSHA is considering how these ACIP and CDC recommendations might impact the requirements in the ETS that take account of individuals' vaccination status (e.g., fully vaccinated, up to date) and seeks comment on this issue.

A.5.2 - Employer Support of Employee Vaccination: OSHA is not considering at this time requiring mandatory vaccination for employees covered by this standard.

- The Healthcare ETS included a provision requiring employers to inform employees about the safety, efficacy, and benefits of vaccination and provide reasonable time and paid leave to each employee for vaccination and side effects experienced following vaccination. OSHA is considering an adjustment to the requirement that would include paid time up to 4 hours, including travel time, for employees to receive a vaccine and paid sick leave to recover from side effects and seeks comment on the approach.
- OSHA is considering requiring employer support for employees who wish to stay up to date on vaccination and boosters in accordance with ACIP and CDC recommendations. OSHA seeks comment on the approach.
- OSHA is considering whether to limit the provisions that provide support for vaccination to employees not covered by the Centers for Medicare & Medicaid Services (CMS) vaccination rule (86 FR 61555) and seeks comment on this approach. The CMS vaccination rule requires healthcare

staff in facilities regulated by CMS to be vaccinated. The majority of healthcare employees covered by this final rule work in facilities covered by the CMS vaccination rule and are subject to the CMS requirements.

A.5.3 - Requirements for Vaccinated Workers: During the initial comment period, stakeholders raised questions about whether the Healthcare ETS requirements should be relaxed or eliminated based on the vaccination status of the individual worker involved, the general vaccination rate of the entire staff, and/or the general vaccination rate of the community. OSHA is considering suggestions that requirements be relaxed:

- for masking, barriers, or physical distancing for vaccinated workers in all areas of healthcare settings, not just where there is no reasonable expectation that someone with suspected or confirmed COVID-19 will be present
- in healthcare settings where a high percentage of staff is vaccinated (OSHA also is accepting comment on what that percentage should be)
- for exposure notification for vaccinated employees

OSHA seeks comment on these approaches.

A.6 - Limited Coverage of Construction Activities in Healthcare Settings: OSHA did not expressly include employers that engage in construction work in hospitals, long-term care facilities and other settings that are covered by the ETS. The construction industry was not included in OSHA's industrial profile for the rule. OSHA is considering clarifying this coverage and seeks comment on this approach. For example, OSHA is considering the same coverage for workers engaged in construction work inside a hospital (e.g.,

installing new ventilation or new equipment or adding a new wall) as for workers engaged in maintenance work or custodial tasks in the same facility. OSHA could consider exceptions for construction work in isolated wings or other spaces where construction employees would not be exposed to patients or other staff.

A.7 - Recordkeeping and Reporting: New Cap for COVID-19 Log Retention Period: The COVID-19 log and reporting provisions, 29 CFR 1910.502(q)(2)(ii), (q)(3)(ii)-(iv), and (r), have remained in effect because OSHA found good cause to forgo notice and comment in light of the grave danger presented by the pandemic. See 86 FR 32559. Now that OSHA is re-opening the comment period for the final rule, the agency also seeks additional comment on 1910.502(q) and (r). In general, OSHA is focused on whether any adjustments to those paragraphs should be made in light of experiences involving the Delta or Omicron variants. In addition, the agency proposes to cap the record retention period for the COVID-19 log at one year from the date of the last entry in the log, rather than the current approach in which that retention period is tied to the duration of the standard (see 29 CFR 1910.502(q)(2)(ii)(C)).

A.8 - Triggering Requirements Based on the Level of Community Transmission: When employees are treating people with suspected or confirmed COVID-19, the ETS requires certain control strategies (e.g., PPE) regardless of community transmission levels. Under the CDC's current guidance for healthcare workers,[1] many requirements for those workers are triggered based on the level of community transmission of COVID-19 (e.g., controls needed in areas of substantial or high transmission, controls not needed in areas

[1] Centers for Disease Control and Prevention (CDC). (2022, February 2). Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic. *https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html*.

of low or moderate transmission). OSHA is considering linking regulatory requirements to measures of local risk, such as CDC's community transmission used in CDC's guidance for healthcare settings or the CDC's COVID-19 Community Levels used in CDC's guidance for prevention measures in community settings.[2] OSHA is seeking comment on that approach, including impacts of such an approach on compliance and enforcement.

A.9 - Evolution of SARS-CoV-2 into a Second Novel Strain: It is possible that a future variant of SARS-CoV-2 will have sufficient genetic drift to be designated another novel coronavirus strain but still results in a disease that is similar to the current illness (e.g., a hypothetical "COVID-22"). OSHA is considering specifying that this final standard would apply not only to COVID-19, but also to subsequent related strains of the virus that are transmitted through aerosols and pose similar risks and health effects. OSHA seeks comment on this approach and alternatives to addressing the potential for new strains related to SARS-CoV-2.

B. Additional Information/Data Requested

OSHA recognizes that the majority of the comment period occurred prior to when the Delta and Omicron variants became prevalent in the United States. OSHA requests new studies or data related to the Delta and Omicron variants since the close of the initial comment period in August 2021, particularly with respect to:

B.1: The average number of days healthcare workers have taken away from work resulting from a COVID-19 infection or quarantine and the percentage of healthcare

[2] See Centers for Disease Control and Prevention (CDC). (2022, February 2); see also Centers for Disease Control and Prevention (CDC). (2022, March 4). COVID-19 Community Levels. *https://www.cdc.gov/coronavirus/2019-ncov/science/community-levels.html*.

workers who have taken days away from work due to a COVID-19 infection or quarantine

B.2: The health effects for fully vaccinated employees, and fully vaccinated and boosted employees, who test positive for COVID-19, including data on days away from work, hospitalizations, long COVID, and fatalities

B.3: The percentage of healthcare workers who are at elevated risk of severe COVID-19 infections (e.g., resulting in hospitalization or extended days away from work), including for age-related or immunocompromised reasons (not based solely on vaccination status)

B.4: The rate of infection, long COVID, hospitalization, and death among healthcare workers compared to those rates among the general adult population

B.5: The health effects and transmission rate of new and emerging variants and sub-lineages of variants, including Omicron BA.2

Additionally, OSHA requests data and information on:

B.6: The vaccination rate among healthcare workers, including the rate of healthcare workers who are fully vaccinated and boosted

B.7: The clinical indicators that will reliably predict the degree of protection afforded by prior infection (i.e., infection-acquired immunity), and how long such protection lasts

B.8: Vaccine efficacy and how such efficacy decreases over time

B.9: The appropriate periodicity of additional vaccine doses and booster doses

B.10: Unintended consequences, such as decreases in staffing retention, or other impacts, such as increases in staffing retention, due to the potential alternatives raised in this notice

C. Information for Economic Analysis

C.1 Industry Profile: For the Healthcare ETS Industry Profile, OSHA based the number of Affected Employees for Affected Industries on whether employees performed healthcare services or healthcare support services under the ETS. If employees did not perform healthcare services or healthcare support services, OSHA did not consider them Affected Employees. See 86 FR 32485. While this approach covered the appropriate North American Industry Classification System (NAICS), the approach may have resulted in an underestimate of Affected Employees. As stated in 29 CFR 1910.502(a), "this section applies to all settings where any employee provides healthcare services or healthcare support services." To address this potential underestimate for the final rule, OSHA is considering revising its approach to base the number of Affected Employees on setting, rather than occupation. OSHA seeks comment on this potential approach.

C.1.1 – Covered Industries

C.1.1A: OSHA acknowledged in the Healthcare ETS that it did not "determine[] how many non-hospital ambulatory care providers will screen patients for COVID-19 infections and symptoms, and therefore might be fully exempt from the standard under paragraph (a)(2)(iii)" of the ETS (86 FR at 32485). While OSHA included in the Healthcare ETS Industry Profile several NAICS outside of healthcare where embedded clinics are prevalent, such as schools, OSHA did not include a number of industries that may have settings with embedded clinics (e.g., embedded clinics in manufacturing facilities) in the industry profile. The Healthcare ETS applies to these embedded clinics, as OSHA made clear both in the regulatory text and the Summary and Explanation for the ETS. See 29 CFR 1910.502(a)(3)(i); 86 FR at 32563. To

address this, OSHA is considering including these industries in the final rule's industry profile. OSHA notes that compliance with the final rule for these industries would most likely result in minimal costs or no costs because, under the Healthcare ETS, OSHA anticipated that many embedded clinics will be fully exempt under the non-hospital ambulatory care exception; and, if the rule applies, it will apply only with respect to embedded clinics and not the entire facility. OSHA seeks comment on this potential approach.

C.1.1B: As discussed above, OSHA noted in the Healthcare ETS that it did not determine "how many non-hospital ambulatory care providers will screen patients for COVID–19 infections and symptoms, and therefore be fully exempt from this rule under paragraph (a)(2)(iii)" (86 FR at 32485). OSHA also noted that "[t]o the extent that providers meet these exemption criteria, they will incur no costs for compliance with respect to these settings," and that "[t]herefore, for this subset of establishments, the costs presented in OSHA's analysis will be dramatic overestimates (i.e., OSHA assumes full costs where costs should be zero)." (Id.) For the final rule, OSHA is considering estimating the number of employers subject to this exemption, if it remains in the standard, but seeks information and data to support such an estimate.

C.1.2 Telework Employees: In the Healthcare ETS, OSHA accounted for reduced employee exposure due to telework for benefits, but did not explicitly account for telework in the number of employees affected by the final rule in the Industry Profile. This may have resulted in an overestimate of several employee-based costs, like the costs of respirators and personal protective equipment, because

OSHA may have overestimated the number of employees affected by the final rule. In the Vaccination and Testing ETS, OSHA adjusted its telework estimates to reflect then-current teleworking conditions (see 86 FR 61462-61467). OSHA is considering making similar adjustments to the final Healthcare rule to estimate the current number of employees who telework. OSHA seeks comment on this potential approach.

C.2 Costs

C.2.1 - One-time costs: OSHA requests comments on the extent to which some costs (e.g., costs associated with initial training, upgrading ventilation, rule familiarization, COVID-19 Plan development, respiratory protection program development) have already been incurred to comply with the ETS. OSHA further requests comments on the extent to which employers and other entities will bear ongoing costs (e.g., ongoing costs associated with training, PPE, respirators and the respiratory protection program, medical removal protection, COVID-19 plan monitoring and modification, and ventilation maintenance) under a final rule.

C.2.2 - Age Group 65-74:

C.2.2A: OSHA had not included employees in the age group 65-74 in the economic analysis of the Healthcare ETS out of concern that the population-wide average of workers in this age bracket would overcount the number of such workers in this sector. See 86 FR at 61470 n. 32. OSHA is rethinking this approach for the Healthcare final rule and seeks comment on including this age group in the analysis of both costs and benefits.

C.2.2B: OSHA will likely update its estimates to reflect the current baseline of vaccinated employees (for example, to incorporate the effects of the CMS vaccine-mandate rule on vaccination rates). OSHA will likely rely on the most recent CDC COVID-19 data tracker, as it did for the Healthcare ETS and the Vaccination and Testing ETS, and may also rely on estimates or data from CMS or other credible sources, to update its estimates. OSHA seeks comment on whether there is other data OSHA should rely on.

C.2.3 – Ancillary Costs:

C.2.3A: In the Healthcare ETS, OSHA offset the cost to employers associated with medical removal and vaccination support with tax credits employers would receive. OSHA is considering how to adjust its methodology in the final rule given the expiration of these tax credits and seeks data and information on this issue. OSHA notes that it could take an approach similar to the one it took in the Vaccination and Testing ETS, i.e., by estimating the number of employers that would (and would not) incur costs because employees could be required to use accrued sick leave benefits for medical removal and vaccination support (Compare 86 FR 32512 (including footnote 61) with 86 FR 61480).

C.2.3B: OSHA is considering updating the manner in which it estimates side effects associated with vaccine doses using CDC estimates (86 FR 32513 & n.63). OSHA is considering following an approach similar to the one it followed in the Vaccination and Testing ETS (86 FR 61480) where OSHA calculated the estimated time off using a more recent study that

surveyed workers at a state-wide healthcare system who had been vaccinated.[3] OSHA seeks data and information on this issue.

C.3 Benefits Data Sources: For the final rule, OSHA is considering using CDC COVID-19 case and fatality data which was unavailable when the Healthcare ETS was initially issued, and seeks comment on this issue. OSHA based the Vaccination and Testing ETS impact analysis on the CDC data which tabulates the respective number of cases and fatalities for the unvaccinated and vaccinated populations.

OSHA also seeks information and data on cases, illnesses, hospitalizations, and fatalities that are specific to employees that would be subject to the final rule (i.e., those in the healthcare field). OSHA notes that it is aware of one potential source that measured deaths in healthcare occupations during the first year of the pandemic.[4]

OSHA is considering using all sources of data on which it relied in the Healthcare ETS and the Vaccination and Testing ETS, as well some new data sources it did not rely on, including, for example:

- CDC Daily Tracker: Daily Tracker Home,[5]
- Demographic Trends of COVID-19 cases and deaths in the US reported to CDC,[6,7,8]

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[3] Levi ML et al. (2021, September 25). COVID-19 mRNA vaccination, reactogenicity, work-related absences and the impact on operating room staffing: A cross-sectional study. Perioperative Care and Operating Room Management preprint. *https://doi.org/10.1016/j.pcorm.2021.100220.*
[4] Kaiser Health News and the Guardian. (2021, April). Lost on the Frontline. The Guardian. *https://www.theguardian.com/us-news/ng-interactive/2020/aug/11/lost-on-the-frontline-covid-19-coronavirus-us-healthcare-workers-deaths-database.*
[5] CDC Daily Tracker: Daily Tracker Home: *https://covid.cdc.gov/covid-data-tracker/#datatracker-home*.
[6] COVID-19 Weekly Cases and Deaths per 100,000 Population by Age, Race/Ethnicity, and Sex: *https://covid.cdc.gov/covid-data-tracker/#demographicsovertime*.
[7] Demographic Trends of COVID-19 cases and deaths in the US reported to CDC: *https://covid.cdc.gov/covid-data-tracker/#demographics*.
[8] Trends in COVID-19 Cases and Deaths in the United States, by County-level Population Factors Maps, charts, and data provided by CDC: *https://covid.cdc.gov/covid-data-tracker/#pop-factors_7daynewcases*.

- Rates of COVID-19 Cases and Deaths by Vaccination Status,[9]
- Rates of laboratory-confirmed COVID-19 hospitalizations by vaccination status,[10]
- United States COVID-19 Cases, Deaths, and Laboratory Testing (NAATs) by State, Territory, and Jurisdiction,[11]
- Nationwide COVID-19 Infection-Induced Antibody Seroprevalence,[12,13]
- Kaiser Health News/UK Guardian,[14]
- US Census: Current Population Statistics,[15]
- The National Panel Study of COVID-19 (NPSC19),[16,17]
- Census Bureau Household Pulse Survey,[18]
- National Center for Health Statistics,[19]
- American Community Survey,[20] and
- Optum Clinformatics Data Mart.[21]

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[9] Rates of COVID-19 Cases and Deaths by Vaccination Status: *https://covid.cdc.gov/covid-data-tracker/#rates-by-vaccine-status*.
[10] *https://covid.cdc.gov/covid-data-tracker/#covidnet-hospitalizations-vaccination*
[11] *https://covid.cdc.gov/covid-data-tracker/#cases_casesper100klast7days*
[12] Nationwide COVID-19 Infection-Induced Antibody Seroprevalence (Commercial laboratories): *https://covid.cdc.gov/covid-data-tracker/#national-lab*.
[13] Nationwide COVID-19 Infection- and Vaccination-Induced Antibody Seroprevalence (Blood donations): *https://covid.cdc.gov/covid-data-tracker/#nationwide-blood-donor-seroprevalence*.
[14] Kaiser Health News and the Guardian. (2021, April). Lost on the Frontline. The Guardian. *https://www.theguardian.com/us-news/ng-interactive/2020/aug/11/lost-on-the-frontline-covid-19-coronavirus-us-healthcare-workers-deaths-database*.
[15] *https://www.census.gov/programs-surveys/cps/data.html*
[16] *https://www.brookings.edu/blog/up-front/2020/08/13/the-covid-19-public-health-and-economic-crises-leave-vulnerable-populations-exposed/*
[17]*https://static1.squarespace.com/static/57c9d7602994ca1ac7d06b71/t/60243c4a2c291024fa12e979/1612987471528/UW_IRP_Grooms_Feb_2021.pdf*
[18] Household Pulse Survey: Measuring Social and Economic Impacts during the Coronavirus Pandemic: *https://www.census.gov/programs-surveys/household-pulse-survey.html*.
[19] *https://www.cdc.gov/nchs/data_access/ftp_data.htm*
[20] *https://www.census.gov/programs-surveys/acs/data.html*
[21] *https://web.uri.edu/optum/*

C.4 Small Business: In developing the Final Regulatory Flexibility Analysis (FRFA), OSHA is seeking comments on whether there are specific issues regarding small covered healthcare entities (i.e., small businesses, small non-profits, and small government jurisdictions) that OSHA should consider, particularly with respect to the technical or economic feasibility of complying with a possible revised rule.

C.5 - Assumptions

C.5.1 Vaccine Efficacy: For the Healthcare ETS, OSHA accounted for vaccine efficacy in its benefits analysis. For the final rule, OSHA is considering accounting for booster efficacy using the CDC Data Tracker, which was the same source for determining vaccine efficacy. OSHA seeks comment on this potential approach and data on which to update its estimates.

C.5.2 Frequency, Severity, and Distribution of Infections: There was "still some uncertainty surrounding the frequency and severity of COVID–19 infections and their distribution" when the Healthcare ETS was issued (86 FR 32545), so OSHA focused that economic analysis on hospitalizations and fatalities. More time and data have brought more certainty regarding other outcomes, so for the final rule OSHA is considering also accounting in its economic analysis for COVID-19-related long-term effects (i.e., long COVID), hospitalization, and shorter illness (due to variants, increased vaccinations, and improved treatments). Additionally, OSHA is considering using an approach similar to that in the Vaccination and Testing ETS, where OSHA took account of breakthrough cases and fatalities in vaccinated employees when it assessed the health impacts. OSHA seeks comment and data on these potential modifications.

II. Informal Public Hearing—Purpose, Rules, and Procedures

One commenter requested that OSHA hold a public hearing on the rulemaking. See OSHA-2020-0004-1034, Attachment 1. OSHA has agreed to do so. OSHA invites interested persons to participate in this rulemaking by providing oral testimony and documentary evidence at the informal public hearing to provide the agency with the best available evidence to use in developing the final rule.

Pursuant to 29 CFR 1911.15(a) and 5 U.S.C. 553(c), members of the public have an opportunity at the informal public hearing to provide oral testimony and evidence on issues raised by the proposal. An administrative law judge (ALJ) presides over each OSHA hearing and will resolve any procedural matters relating to the hearing.

OSHA's regulation governing public hearings (29 CFR 1911.15) establishes the purpose and procedures of informal public hearings. Although the presiding officer of the hearing is an ALJ and questioning of witnesses may be allowed on crucial issues, the proceeding is largely informal and essentially legislative in purpose. Therefore, the hearing provides interested persons with an opportunity to make oral presentations in the absence of rigid procedures that could impede or protract the rulemaking process. The hearing is not an adjudicative proceeding subject to the Federal Rules of Evidence. Instead, it is an informal administrative proceeding convened for the purpose of gathering and clarifying information. Accordingly, questions of relevance, procedure, and participation generally will be resolved in favor of developing a clear, accurate, and complete record within the available time frame.

The available time frame for this rulemaking is short as the agency hopes to complete the rulemaking as quickly as possible. OSHA remains aware of the dangers to

healthcare workers exposed to COVID-19, as well as the potential for new variants and the surges of patients with COVID-19 that could follow in healthcare. Pursuant to 29 CFR 1911.4, the Assistant Secretary may, on reasonable notice, issue additional or alternative procedures to expedite the proceedings.

Although the ALJ presiding over the hearing makes no decision or recommendation on the merits of the proposal, the ALJ has the responsibility and authority necessary to ensure that the hearing progresses at a reasonable pace and in an orderly manner. To ensure a full and fair hearing, the ALJ has the power to regulate the course of the proceedings; dispose of procedural requests, objections, and comparable matters; confine presentations to matters pertinent to the issues the proposed rule raises; use appropriate means to regulate the conduct of persons present at the hearing; question witnesses and permit others to do so; limit such questioning; and leave the record open for a reasonable time after the hearing for the submission of additional data, evidence, comments, and arguments from those who participated in the hearing (29 CFR 1911.16).

At the close of the hearing, there will be a post-hearing comment period during which stakeholders may submit final briefs, arguments, summations, and additional data and information to OSHA.

III. Notice of Intention to Appear at the Hearing

Interested persons who intend to provide oral testimony or documentary evidence at the hearing must file a written NOITA prior to the hearing and in accordance with the instructions in the **"ADDRESSES"** section earlier in this document. To testify at the hearing, interested persons must electronically submit their NOITA on or before

[INSERT DATE 14 DAYS AFTER PUBLICATION IN THE FEDERAL REGISTER]. The NOITA must provide the following information:

(1) Name, address, email address, and telephone number of each individual who will give oral testimony;

(2) Name of the establishment or organization each individual represents, if any;

(3) Occupational title and position of each individual testifying; and

(4) A brief statement of the position each individual will take with respect to the issues raised by the ETS (e.g., "I generally support/oppose the whole standard," "the requirement for [specific provision] should be removed," "the scope of the rule should be changed to include/exclude …").

The agency will consider the information in each submission when setting the hearing schedule. Before the hearing, OSHA will make the hearing procedures and hearing schedule available at *https://www.osha.gov/coronavirus/healthcare/rulemaking* and in the docket. OSHA emphasizes that the hearing is open to the public; however, only individuals who file a NOITA may testify at the hearing.

IV. Certification of the Hearing Record and Agency Final Determination

Following the close of the hearing and the post-hearing comment period, the ALJ will certify the record to the Assistant Secretary of Labor for Occupational Safety and Health. The record will consist of all of the written comments, oral testimony, and documentary evidence received during the proceeding. The ALJ, however, will not make or recommend any decisions as to the content of the final standard. Following certification of the record, OSHA will review all the evidence received into the record and will issue the final rule based on the record as a whole.

Authority and Signature

This document was prepared under the direction of Douglas L. Parker, Assistant Secretary of Labor for Occupational Safety and Health, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. It is issued under the authority of sections 4, 6, and 8 of the Occupational Safety and Health Act of 1970 (29 U.S.C. 653, 655, 657); Secretary of Labor's Order No. 8-2020 (85 FR 58393 (Sept. 18, 2020)); 29 CFR part 1911; and 5 U.S.C. 553.

Douglas L. Parker,

Assistant Secretary of Labor for Occupational Safety and Health.

[FR Doc. 2022-06080 Filed: 3/22/2022 8:45 am; Publication Date: 3/23/2022]